MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00386 97 810

Reg. Dist. No.

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 mo.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Georgie Bankard

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

B.(b) Name of husband or wife Charles Bailey Bankard

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Mar. 19 1876

8. AGE:

Years	Months	Days	If less than one day
70	9	14	hrs. min.

9. Birthplace New Windsor, Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER

12. Name George Bupp

13. Birthplace New Windsor, Md.

MOTHER

14. Maiden name Josephine Barnes

15. Birthplace New Windsor, Md.

16. Informant Mrs Blanchard Martin

Address Union Bridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 3 - 1947 (month) (day) (year)

Cemetery or crematory Presbyterian Cemetery

Location New Windsor Md.

18. Funeral director H Bankard & Son

Address Westminster, Md.

19. Jan 4 19 47 (Date rec'd by registrar) Fred L Reifsnyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 3 19 47 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 47 19 46 to Jan 3 19 47 and that I last saw h alive on Jan 3 19 47

Immediate cause of death

Arteriosclerosis

Due to Senile and Uremia

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings at operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J H Long M. D. or other

Address Union B Date signed 1-3-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164 e

00587

CERTIFICATE OF DEATH

Reg. Dist. No. 740

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yr., 2 mo., 27 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 7 yr., 2 mo., 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 714 W. Lombard Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William Barnes

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September, 1911

8. AGE: Years	Months	Days	If less than one day
35	3		hrs. min.

9. Birthplace: Baltimore City, Maryland
(Town, county, and state)
10. Usual occupation: odd jobs
11. Industry or business:

FATHER
12. Name: Adam Barniski (Barnes)
13. Birthplace: Lithuania

MOTHER
14. Maiden name: Nellie
15. Birthplace: Lithuania

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 18, 1947 (month) (day) (year)
Cemetery or crematory: Holy Redeemer Cem.
Location: Balto. Md.
18. Funeral director: Joseph Kasinskas Inc.
Address: 602 Washington Blvd.
19. Jan. 17 1947 C. Harry Zilpp Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 16 1947 at 12:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Fractured Skull	
Due to	
Due to	
Other conditions: Schizophrenia, paranoid type	17 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 1-16-47
Where did injury occur? Sykesville, Carroll Co., Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) State Hospital
Means of injury: jumped down stairwell Injured at work? no.

23. SIGNATURE: James T. Marsh Deputy Medical Examiner
M. D. or other
Address: Baltimore Md. Date signed: 1-16-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

178 ★ 00388

Reg. Dist. No. 7.0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: N. Y. County:

City or town: New Hampton

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 1

(If rural, give LOCATION)

2.(a) If veteran, name war: /

3.(a) FULL NAME: Alfred E. Bates

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	married

6.(b) Name of husband or wife: Edith Nash Bates

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 17 1892

8. AGE: Years: 54 Months: 11 Days: 9 If less than one day: hrs. min.

9. Birthplace: Wellsboro, Pa (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: George Bates

13. Birthplace: Pa

MOTHER — 14. Maiden name: Eva Grinnell

15. Birthplace: Pa

16. Informant: Alfred G. Bates

Address: Suffex, N. J.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 31, 1947 (month) (day) (year)

Cemetery or crematory:

Location: Middletown, N. Y.

18. Funeral director: C. D. Moser & Son

Address: Taneytown, Md

19. Jan 27, 1947 (Date rec'd by registrar) Ethel M. McKinney Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 26 1947, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death: Fractured skull

Due to: Traumatic Amputation both Legs.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: Jan. 26-47

Where did injury occur? Taneytown Carroll Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Aeroplane Crash Injured at work? No

23. SIGNATURE: James T. Marsh Deputy Medical Exam'r

M. D. or other

Address: Westminster Md Date signed: 1-26-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

173

00389

CERTIFICATE OF DEATH

★ Reg. Dist. No. 78

1. PLACE OF DEATH:

County: Carroll

City or town: Taneytown Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Transient

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: N. Y. County: [redacted]

City or town: New Hampton

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: William Henry Bates

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 2, 1926

8. AGE:

Years	Months	Days	If less than one day
20	2	24	hrs. min.

9. Birthplace: New Hampton, N.Y. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER — 12. Name: Alfred E Bates

13. Birthplace: Pa

MOTHER — 14. Maiden name: Edith Nash

15. Birthplace: Brooklyn. N.Y.

16. Informant: Alfred E. Bates

Address: Suffex. N.J.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 31, 1947 (month) (day) (year)

Cemetery or crematory:

Location: Middletown N.Y.

18. Funeral director: C. D. Sias & Son

Address: Taneytown, Md.

19. Jan 27 1947 (Date rec'd by registrar) Ethel M. McKenney Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 26 1947, at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Frac. cervical Vertebrae	
Multiple frac. scull, jaw bones and mandible — Frac. both lower	
Due to: Leg —	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Jan 26-47

Where did injury occur? Taneytown (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Aeroplane Crash Injured at work? no

23. SIGNATURE: James T. Marsh Deputy Medical Examiner (M. D. or other)

Address: Westminster Md Date signed: 1-26-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

00390

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY. WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months, 11 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 2 months, 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sampson Willis Beavers

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Sarah Catherine Lizier

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 21, 1877

8. AGE:

Years	Months	Days	If less than one day
69	7	10	hrs. min.

9. Birthplace: Fairfax County, Virginia (Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: agriculture

FATHER 12. Name: Unk —

13. Birthplace: Virginia

MOTHER 14. Maiden name: Unk.

15. Birthplace:

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 2-1-47 (month) (day) (year)

Cemetery or crematory:

Location: Washington, D.C.

18. Funeral director: H. W. Chambers Co.

Address 5801 Cleveland ave. Riverdale, Md.

19. Feb. 1 1947 (Date rec'd by registrar) C. Tracy Dees Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 31, 1947, at 3:25 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 6 1947, to January 31, 1947

and that I last saw him alive on January 31, 1947

Immediate cause of death	DURATION
Arteriosclerosis, more than	3 years
Due to	
Due to	
Other conditions: Psychosis with cerebral arteriosclerosis	3 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D. M. D., or other

Springfield State Hospital

Address: Sykesville, Maryland Date signed: 1-31-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

169

00391

CERTIFICATE OF DEATH

Reg. Dist. No. 800

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Not. County: Known

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James Bratton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	not Known

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): not Known 1866

8. AGE: Years: about 80 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: not Known (Town, county, and state)

10. Usual occupation: Wayfarer

11. Industry or business:

FATHER 12. Name: not

13. Birthplace: Known

MOTHER 14. Maiden name: not

15. Birthplace: Known

16. Informant:

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 7 - 1947 (month) (day) (year)

Cemetery or crematory: Carroll County Home Cem.

Location: Westminster, Md.

18. Funeral director: H. H. Hartzler & Sons

Uniontown Bridge & New Windsor, Md.

19. Jan 6 1947 (Date rec'd by registrar) Ernest Bowling Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 4 1947 at 5:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Fracture of Skull	
Fracture Left elbow	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Jan 5, 47

Where did injury occur? New Windsor Carroll Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Walnut Md Railroad

Means of injury: Struck by train Injured at work? No

23. SIGNATURE: James T. Marsh Deputy Medical Examiner

M. D. or other

Address: Westminster Md Date signed: 1-5-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00592

CERTIFICATE OF DEATH

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yr's, 9 Mo's, 13 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colorad Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Edesville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MATILDA BROWN

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Lewin Brown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 22, 1885

8. AGE:	Years	Months	Days	If less than one day
	61	5	18	hrs. min.

9. Birthplace: Edesville, Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Antinio Smallwood
13. Birthplace: Unknown

MOTHER
14. Maiden name: Jane Jones
15. Birthplace: Unknown

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 14-47 (month) (day) (year)
Cemetery or crematory: Rock Hall
Location: Rock Hall Md
18. Funeral director: Edgar L Lane
Address: Chmnd Hill Md

19. 1/10 19 47 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10, 19 47, at 9.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 27 19 42 to Jan. 10 19 47 and that I last saw her alive on January 10, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1942
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben W Lowman M.D.
M. D. or other
Address: Henryton, Md. Date signed 1/10/47

1-25

2-740-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

00393

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr 6 mos 17 da

Hospital, institution, or street address (if not at home): Springfield State Hospital

How long in hospital or institution? 1 yr 6 mos 17 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County:

City or town: 3002 Ruckert Ave Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Rosella Burke

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 22 - 1869

8. AGE: Years: 77 Months: 8 Days: 8 If less than one day: hrs. min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Dependent

11. Industry or business:

FATHER — 12. Name: John J. Burke

13. Birthplace: Ireland

MOTHER — 14. Maiden name: Winifred Fleming

15. Birthplace: Baltimore

16. Informant: Mrs Mary Pfeifer 3002 Ruckert Ave, Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-3-47 (month) (day) (year)

Cemetery or crematory: New Catholic Cem.

Location: Balto. Md.

18. Funeral director: E. J. Fleming & Son

Address: 1938 E. Lafayette Ave.

19. Jan. 31 1947 C. Harry Klein Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 31st 1947, at 1.20 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 13th 1945, to Jan 31st 1947 and that I last saw h[illegible] alive on Jan 31st 1947

Immediate cause of death: Cerebral hemorrhage — Duration: 2 wks

Due to: Hard Arteriosclerosis — Duration: 20 yr

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. J. Hastings M. D. (M. D. or other)

Address: Sykesville Date signed: 2/3/47

1-35-

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00394

94a

SW

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County Carroll
City or town New Windsor Rural (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Dennings
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Carroll
City or town New Windsor, Rural (If outside city or town limits, write RURAL and give nearest town)
Street No. Dennings (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Greenwood Byers

3.(b) Social Security Number none

4. Sex female
5. Color or race white
6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband ~~or wife~~ Edward M. Byers
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan. 19 - 1863

8. AGE: Years 83 Months 11 Days 27 If less than one day hrs. min.

9. Birthplace Carroll County, Md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business At home
FATHER 12. Name Wallace Naill
13. Birthplace Maryland
MOTHER 14. Maiden name Ann Baile
15. Birthplace Maryland
16. Informant Edward M. Byers
Address New Windsor, Md R. D.
17. Burial (Burial, cremation, or removal. Which) Date thereof Jan. 18 - 1947 (month) (day) (year)
Cemetery or crematory Bethel Cemetery
Location Sams Creek Md
18. Funeral director D. D. Hartzler & Sons
Address Union Bridge & New Windsor, Md.
19. Jan 17 1947 (Date rec'd by registrar) Ernest J. Bucher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 16 1947, at 7:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from About 2 yrs to 19 and that I last saw her alive on Jan 15 1947

	DURATION
Immediate cause of death General arteriosclerosis; in particular coronary sclerosis	several yrs
Due to senile changes	2 yrs
Due to chronic enteritis " bronchitis	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [illegible signature] M. D. or other
Address 3902 Greenland Rd Balto 15, Md. Date signed 1-17-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00396

1700

Reg. Dist. No. 7-6

1. PLACE OF DEATH:
County: Carroll
City or town: rural Westminster R 140
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 5403 Reisterstown Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Eugene Connolly

3.(b) Social Security Number: 179-20-7653

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 20, 1873

8. AGE: Years	Months	Days	If less than one day
73	3	23	hrs. min.

9. Birthplace: Mount Vernon Balto, Co. Md.
(Town, county, and state)
10. Usual occupation: none ? 10 hours
11. Industry or business: Hanover Cordage Co

MOTHER FATHER
12. Name: Michael Connolly
13. Birthplace: Maryland

MOTHER
14. Maiden name: Nancy Anne Ennis
15. Birthplace: Maryland

16. Informant: Maryland State Police
Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 15, 1947 (month) (day) (year)
Cemetery or crematory: Carroll County Home
Location: near Westminster, Maryland
18. Funeral director: J. Francis Reese
Address: Westminster, Md.

19. 1/15 19 47 (Date rec'd by registrar) L. L. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 12th 1947, at 9:C. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
multiple fractures including fracture of the skull	
Due to: accident	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 1-12-47
Where did injury occur? near Westminster, Carroll, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Route 140 by motor vehicle
Means of injury: Apparently struck by motor vehicle Injured at work? no

23. SIGNATURE: J. T. Billingslea, M.D.
Acting Deputy Med. Exam. M. D. or other
Address: Westminster, Md. Date signed: 1-14-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00397

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 807 S. Greene Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: JESSE CORNISH

3.(b) Social Security Number: 212-01-8326

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Gertrude Cornish
6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): May 6, 1904

8. AGE:

Years	Months	Days	If less than one day
42	8	9	....hrs. ....min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
MOTHER FATHER
12. Name: Willie Cornish
13. Birthplace: Maryland
MOTHER
14. Maiden name: Martina Molock.
15. Birthplace: Maryland
16. Informant: Deceased
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-18-47 (month) (day) (year)
Cemetery or crematory Mt. Calvary cem.
Location Anne Arundel County
18. Funeral director Walter B. Spriggs
Address 139 Hamburg St.
19. 1/15 (Date rec'd by registrar) 19 47 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 15, 1947, at 7.15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 13, 1947 to Jan. 15, 1947 and that I last saw him alive on January 15, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Unknown
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert W. Swan, M. D.
M. D. or other
Address Henryton, Md. Date signed 1/15/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-25

2- 740 —— 1-1?

Item 21: Dr. Hoffman's statement 1/20/47 G108 Microfilm -LL

Item

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13C 00398

BC Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 2 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1320 Orleans St.,
(If rural, give LOCATION)
2.(a) If veteran, name war V

3.(a) FULL NAME LILLIAN CORNISH

3.(b) Social Security Number 220-22-5359

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 17, 1927

8. AGE: Years	Months	Days	If less than one day
19	7	24	hrs. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual occupation Cannery Worker
11. Industry or business

FATHER
12. Name Graston Cornish
13. Birthplace Maryland

MOTHER
14. Maiden name Pansy Cole
15. Birthplace Maryland

16. Informant Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/16/47 (month) (day) (year)
Cemetery or crematory Mt Calvary
Location Brooklyn, Md.
18. Funeral director Elroy O. Wilson
Address 1000 Brantly Ave

19. 1/11 19 47 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 11, 19 47, at 1.00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 9, 19 46, to Jan. 11, 19 47 and that I last saw her alive on January 11, 19 47

Immediate cause of death — DURATION
Pulmonary Tuberculosis
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.
M. D. or other
Address Henryton, Md. Date signed 1/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Include age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-25-

2-740-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00399

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr. 2 mo's, 22 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 903 Pennsylvania Avenue (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: CLARENCE FRANCIS COUNTS

3.(b) Social Security Number: 160-18-0236

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 31, 1921

8. AGE: Years	Months	Days	If less than one day
25	9	28	hrs. min.

9. Birthplace: Ponaira, S. C. (Town, county, and state)

10. Usual occupation: Presser

11. Industry or business:

FATHER — 12. Name: John Counts

13. Birthplace: Ponaira, S. C.

MOTHER — 14. Maiden name: Alberta Bates

15. Birthplace: Ponaira, S. C.

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-3-47 (month) (day) (year)

Cemetery or crematory: Mt. Calvary Cemetery

Location: Cedar Hill Md.

18. Funeral director: Nicholas Halstead

Address: 918 Druid Hill Ave

19. 1-29 19 47 (Date rec'd by registrar) Albert R. Swarbman Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 29, 19 47, at 10.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 7, 19 45 to Jan., 29, 19 47 and that I last saw h... im alive on January 29, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1st 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statisticaDy.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Reuben A. Ashman, M. D. (M. D. or other)

Address: Henryton, Md. Date signed: 1-29-47

1-25

2-740 — 1-10

Evidence for the change of age is shown on G 108 1/20/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00400

95C

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Westminster Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs

Hospital, institution, or street address where death occurred:

County Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mr Harvey E. Crist

3. (b) Social Security Number Jon

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Widowed

6.(b) Name of husband or wife Mollie Crissner

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 19 1868

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
78	10	25		

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Robert Crist

13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden name Annie F Engle

15. Birthplace Carroll Co. Md.

16. Informant George Bankard Husband

Address Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 16 - 1947 (month) (day) (year)

Cemetery or crematory Meadow Branch Cem.

Location Westminster Md.

18. Funeral director D Bankard & Son

Address Westminster Md.

19. 1/14 - 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1 - 14 1947, at 1 00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-10- 1946, to 1-14 1947

and that I last saw him alive on 1-12- 1947

Immediate cause of death Cardiac decompensation — DURATION 4 weeks

Due to Hypertension — DURATION 4 years?

Due to Uterine adenocarcinoma — DURATION 4 years?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE N. C. Hyde M. D. or other

Address Westminster, Md. Date signed 1-14-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00401

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 206 Broad Street
(If rural, give LOCATION)
2.(a) If veteran, name war World War No 1

3.(a) FULL NAME: JOHN DORMAN

3.(b) Social Security Number: 214-10-6534

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 15, 1896

8. AGE: Years	Months	Days	If less than one day
50	7	23	..... hrs. ..... min.

9. Birthplace Salisbury, Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER
12. Name John Dorman, Sr.
13. Birthplace Maryland

MOTHER
14. Maiden name Annie Deshild
15. Birthplace Maryland

16. Informant Deceased
Address Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 13-47 (month) (day) (year)
Cemetery or crematory Hanston
Location Salisbury Md

18. Funeral director James T. Stewart
Address Salisbury Md

19. 1/8 1947 (Date rec'd by registrar) Deputy local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8, 1947 at 10.40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 17, 1946 to Jan. 8, 1947 and that I last saw him alive on January 8, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Oct. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did Injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Reuben Wyman M.D.
M. D. or other
Address Henryton, Md. Date signed 1/8/47

VS A15-1 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-25

2-740-1-11

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00402

526

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Rural Westminster # 7
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Rural Westminster # 7
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Charles Edward Eckard

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Ellen A. Heldebridle
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 21 - 1867

8. AGE: Years	Months	Days	If less than one day
79	8	21	hrs. min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Farmer R.F.
11. Industry or business
FATHER 12. Name George W. Eckard
13. Birthplace Md.
MOTHER 14. Maiden name Joanna Zumbaum
15. Birthplace Md.
16. Informant Samuel Myers
Address Westminster, Md. RD # 7
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 15 - 1947 (month) (day) (year)
Cemetery or crematory Pleasant Valley Cemetery
Location Westminster Md. RD #7
18. Funeral director H. Bankard & Son
Address Westminster, Md.
19. 1/16 1947 L.L. Crumbacker
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12 1947, at 2 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 12 1946, to Jan. 11 1947
and that I last saw him alive on January 11th 1947

Immediate cause of death	DURATION
Cancer of Bladder	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John I Stewart M. D. or other
Address Westminster Md Date signed Jan. 13 - 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

00403

CERTIFICATE OF DEATH

Reg. Diat. No. 740

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 yrs 5 mo 12 da

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 34 yrs 5 mo 12 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)

State: Md County:

City or town: Baltimore Md (If outside city or town limits, write RURAL and give nearest town)

Street No.: (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Ethel Fairbank

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 18 th - 1889

8. AGE: Years 57 | Months 9 | Days 21 | If less than one day: hrs. min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Dependent

11. Industry or business:

FATHER 12. Name: John C Fairbank

13. Birthplace: Baltimore

MOTHER 14. Maiden name: Ida L Burton

15. Birthplace: Baltimore

16. Informant: Mrs J. A Burton

Address: 511 E. Rolling Rd. Baltimore

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 10, 1947 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville, Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. Jan. 10 1947 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 7th 1947 at 7-45 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 27 1942 to Jan 7th 1947 and that I last saw h.. alive on Jan 7th 1947

Immediate cause of death	DURATION
Acute Coronary Occlusion	5 hrs
Due to:	
Epilepsy	50 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: Coronary Occlusion

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W J Haslup M.D. M. D. or Other

Address: Sykesville Md. Date signed: 8/47

1-35

00404

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131 B

CERTIFICATE OF DEATH

Reg. Dist. No. 83

1. PLACE OF DEATH:
County: Carroll
City or town: Berrett
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yr
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Berrett
(If outside city or town limits, write RURAL and give nearest town)
Street No. R. D. Sykesville Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: William J. Gearhart (Gearheart)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband or~~ wife: Rachel A. Gearheart deceased 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 27, 1871

8. AGE: Years 75 | Months 3 | Days 8 | If less than one day ..... hrs. ..... min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: Carpenter (retired)

11. Industry or business:

FATHER
12. Name: Henry Gearheart
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary J. Ridgely
15. Birthplace: Maryland

16. Informant: Mrs. Ridgely Gearheart
Address: Sykesville Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 1-7-47 (month) (day) (year)
Cemetery ~~or crematory~~: Brandenburg
Location: Berrett, Carroll Co. Maryland

18. Funeral director: C. W. Walsh
Address: Winfield, Md.

19. Jan 7 1947 (Date rec'd by registrar) Edna M. Hewitt Registrar
Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 5, 1947 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 15 1946, to Jan 1947
and that I last saw h~~im~~~~e~~ alive on Jan 1947

Immediate cause of death	DURATION
Uremic Poison	2 wks
Due to Chronic Nephritis	
Due to Hypertrophy of Prostate	3
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm. E. Martin M. D. or other
Address: Randallstown Date signed 1/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a 00405

CERTIFICATE OF DEATH

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Manchester (If outside city or town limits, write RURAL and give nearest town)
Street No.: York St (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Ellen Garrett

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Horatio R. Garrett
6.(c) If alive, give age: 81 years

7. Birth date of deceased (mo., day, yr.): March 20, 1866

8. AGE:

Years	Months	Days	If less than one day
80	10	8	...hrs. ...min.

9. Birthplace: Carroll County, Md (Town, county, and state)
10. Usual occupation: House wife
11. Industry or business

FATHER
12. Name: Jessie Albert Dawn
13. Birthplace: Carroll Co. Md

MOTHER
14. Maiden name: Catharine Ann Stone
15. Birthplace: Carroll Co. Md

16. Informant: Horatio R. Garrett
Address: Manchester

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-1-47 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Manchester, Md.

18. Funeral director: Jacob Waike's Sons
Address: Manchester, Md.

19. Jan. 31 1947 (Date rec'd by registrar) Mrs. W. G. Sellers Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 29 1947 at 2:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 27 1947 to January 29 1947 and that I last saw her alive on January 28 1947

Immediate cause of death	DURATION
Coronary Thrombosis	24 hours
Due to: Coronary Arterio-sclerosis	1 year
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Maurice C. Carterfield M. D. or other
Address: Hampstead Md Date signed: 1-29-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01930

CERTIFICATE OF DEATH

Reg. Dist. No. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge (If outside city or town limits, write RURAL and give nearest town)

Street No.: Main Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Flora Mazzeppa Sittings

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Edward Sittings

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 6, 1871

8. AGE:

Years	Months	Days	If less than one day
75	9	6	____ hrs. ____ min.

9. Birthplace: Frederick Co. Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER

12. Name: John H. Hustmann

13. Birthplace: Fred. Co. Maryland.

MOTHER

14. Maiden name: Elmora Hartzler

15. Birthplace: Fred. Co. Maryland.

16. Informant: Miss Louisa C. Hustmann

Address: Union Bridge, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 14-1947 (month) (day) (year)

Cemetery or crematory: Mt Zion Cemetery

Location: McKaig - Mt Pleasant

18. Funeral director: D. D. Hartle & Son

Address: Union Bridge & New Windsor Md

19. Jan. 14 1947 (Date rec'd by registrar) Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12 1947, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947 to Jan 11 1947 and that I last saw h[illegible] alive on Jan 11 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: J. H. Mowbray M.D. M. D. or other

Address: Westminster Date signed: Jan 12

2-25

2-810 —— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00406

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months, 8 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St. Mary's
City or town: Hermansville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: BENJAMIN FRANKLIN GORDON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 10, 1881

8. AGE: Years	Months	Days	If less than one day
65	4	25	..... hrs. ..... min.

9. Birthplace (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: ? Gordon
13. Birthplace: St. Mary's Co., Md.

MOTHER
14. Maiden name: Josephine Hardy
15. Birthplace: St. Mary's Co., Md.

16. Informant: Deceased
Address

17. (Burial, cremation, or removal. Which?) Burial — Date thereof (month) 1 (day) 7 (year) 1947
Cemetery or crematory: Holy Face
Location: Great Mills Md
18. Funeral director: Robinson Funeral Home
Address: Leonardtown Md.
19. (Date rec'd by registrar) 1/3 1947 — Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 3, 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25, 1946, to Jan. 3, 1947
and that I last saw h... im alive on January 3, 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Jan. 12 1946
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Freeman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 1/3/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

1-25

2-740 - 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00407

Reg. Diat. No. 74 1

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1203 W. Lexington Street (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: SAMUEL GREEN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Missouri Green

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): July 26, 1902

8. AGE: Years: 44 Months: 5 Days: 28 If less than one day: hrs. min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Shipyard Worker

11. Industry or business:

FATHER 12. Name: Samuel Green, Sr.

13. Birthplace: North Carolina

MOTHER 14. Maiden name: Emily (Unknown)

15. Birthplace: North Carolina

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-29-47 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Balto. City

18. Funeral director: Samuel W. Sullivan Jr.

Address: 1011 N. Arlington Ave

19. 1-24 (Date rec'd by registrar) 19 47 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24, 1947, at 11.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 20, 1947 to Jan. 24, 1947 and that I last saw him alive on January 24, 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Nov. 1st 1946

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Md. Date signed 1-24-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-25

2-740 — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00498

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 17 days

Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 8422 Georgia Ave.,
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: SAMUEL GORDON GREEN

3.(b) Social Security Number: 578-16-8447

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 5, 1911

8. AGE: Years	Months	Days	If less than one day
35	6	15	..... hrs. ..... min.

9. Birthplace: North Carolina
(Town, county, and state)

10. Usual occupation: Tailor

11. Industry or business

FATHER — 12. Name: Arthur Green

FATHER — 13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Ida Roger

MOTHER — 15. Birthplace: North Carolina

16. Informant: Deceased

Address

17. Burial, (Burial, cremation, or removal. Which?) Date thereof Jan. 25-47 (month) (day) (year)

Cemetery or crematory: Woodlawn Cemetery

Location: Washington D.C.

18. Funeral director: Carey & Latney

Address: 611 - K. St. N.W. Wash D.C.

19. 1-20 (Date rec'd by registrar) 19 47 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20, 1947 at 10.00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 3, 1946 to Jan. 20, 1947 and that I last saw him alive on January 20, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other

Address: Henryton, Md. Date signed 1-20-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-25

2-740-2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00409

94a ★

CERTIFICATE OF DEATH

Reg. Dist. No. 700

1. PLACE OF DEATH:

County Carroll

City or town Harney

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Carroll

City or town Harney Taneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Clifford L. Hahn

3.(b) Social Security Number 198-10-2081

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Estella Stambaugh Hahn

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 25, 1881

8. AGE: Years 65 | Months 8 | Days 0 | If less than one day ..... hrs. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation carpenter

11. Industry or business

FATHER 12. Name William Hahn

13. Birthplace Md.

MOTHER 14. Maiden name Alice Morningstar

15. Birthplace Md

16. Informant Estella Stambaugh Hahn

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 28, 1947 (month) (day) (year)

Cemetery or crematory Lutheran

Location Harney, Md.

18. Funeral director C. O. FUSS & SON

Address Taneytown, Md.

19. Jan 28 1947 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1947, at 6:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 4 1947, to Jan. 25 1947

and that I last saw h.i.m. alive on Jan. 22 1947

Immediate cause of death	DURATION
Acute Coronary Occlusion	Few Min.
Due to Coronary Arteriosclerosis and Hypotension	3 Yrs.
Due to	
Other conditions Generalized Arteriosclerosis Obesity	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R. S. McVaugh M. D. M. D. or other

Address Taneytown, Md. Date signed 1/27/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00410 80

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ida May Harner

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband ~~or wife~~ Emanuel Harner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 24-1868

8. AGE: Years 78 | Months 8 | Days 19 | If less than one day ..... hrs. ..... min.

9. Birthplace Carroll County, Md

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name Christian Daylhoff

13. Birthplace Maryland

14. Maiden name Caroline Snyder

15. Birthplace Maryland

16. Informant Mrs. Bernard Wenhaar

Address New Windsor, Md

17. Burial Date thereof Jan. 16-1947

(Burial, cremation, or removal? Which?) (month) (day) (year)

Cemetery or crematory Lutheran Cemetery

Location Uniontown, Md

18. Funeral director H. L. Hartzler & Sons

Address Union Bridge & New Windsor, Md.

19. Jany 15 1947 Grace E. Speicher Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13 1947, at 1:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 12 1947, to Jan. 12 1947

and that I last saw h[illegible] alive on Jan. 12 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	15 hrs
Due to: Arterio Sclerosis Essential Hypertension, & myocardial degeneration	10-15 yrs
Other conditions: Cerebral Hemorrhage	1940
Spastic Paralysis Legs & Arm	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Luther Speicher M. D. or other

Address Westminster, Md. Date signed 1/15/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13 F * 00411

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs., 27 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 545 Bloom Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME ARLENE HOLLAND

3.(b) Social Security Number 219-10-7415

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20, 1910

8. AGE: Years	Months	Days	If less than one day
36	9	18	hrs. min.

9. Birthplace Frederick, Md.
(Town, county, and state)
10. Usual occupation Riveter
11. Industry or business

FATHER
12. Name Charles Holland
13. Birthplace Frederick, Md.

MOTHER
14. Maiden name Rosie Diggs
15. Birthplace Frederick, Md.

16. Informant Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-11-47 (month) (day) (year)
Cemetery or crematory Mt. Auburn
Location Baltimore, Md.
19. Funeral director Mrs. George A. Holland
Address 1631 Druid Hill Ave.

19. 1/8 (Date rec'd by registrar) 19 47 Albert R. Sundheim Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 8 19 47, at 9.25A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 11, 1943, to Jan., 8, 1947
and that I last saw her alive on January 8 1947

Immediate cause of death Pulmonary Tuberculosis — DURATION: Oct. 1943
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben W. Swan, M.D. M. D. or other
Address Henryton, Md. Date signed 1/8/47

1-25

2-240 - 1-12

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0C412

Reg. Dist. No. 820

1. PLACE OF DEATH:
County: Carroll
City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: HOWARD H. HOOD

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Goldie M. Hood
6.(c) If alive, give age: 58 years
7. Birth date of deceased (mo., day, yr.): July 28, 1891

8. AGE: Years	Months	Days	If less than one day
55	5	22	hrs. min.

9. Birthplace: Frederick Co. Maryland (Town, county, and state)
10. Usual occupation: Salesman
11. Industry or business: Mt. Airy Milling Co.
FATHER 12. Name: Oliver Hood
13. Birthplace: Maryland
MOTHER 14. Maiden name: Annie Watkins
15. Birthplace: Maryland
16. Informant: Mrs. Goldie M. Hood
Address: Mt. Airy, Maryland
17. (Burial, ~~cremation, or removal. Which?~~) Burial Date thereof 1-22-47 (month) (day) (year)
Cemetery ~~or crematory~~: Prospect
Location: nr. Mt. Airy, Frederick Co. Md.
18. Funeral director: C. M. Waltz
Address: Winfield, Md.
19. (Date rec'd by registrar) Jan. 21 19 47 Registrar: Wm D Snyder

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20, 1947 at 12:30 A M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 17, 1947, to Jan. 20, 1947 and that I last saw him alive on January 19, 1947

Immediate cause of death	Duration
Hemiplegia (right)	3 day
Due to: Hypertension	2 yrs
Due to: Cardio-vaacular desease	? yrs.
Other conditions: Asthma	6 mo.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: non
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Stanley Grabill M.D. M. D. or Other
Address: Mt Airy Md Date signed 1/20/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940 * 0C413

CERTIFICATE OF DEATH

Reg. Dist. No. 760

1. PLACE OF DEATH:
County: Carroll Co
City or town: Rural near Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Most of life
Hospital, institution, or street address where death occurred:
Sullivan Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town: Rural near Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. Sullivan Road
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I.

3. (a) FULL NAME: Harry Clinton Hunter

3. (b) Social Security Number: 219-01-0305

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Lena Baron Hunter
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 27. 1893

8. AGE:

Years	Months	Days	If less than one day
53	3	25	..... hrs. ..... min.

9. Birthplace: Westminster, Carroll Co. Md.
(Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business

FATHER
12. Name: William Hunter
13. Birthplace: Carroll Co. Md.

MOTHER
14. Maiden name: Alverta Keller
15. Birthplace: New Rock. Pa.

16. Informant: Mrs. Harry C. Hunter
Address: Westminster, R.D. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/25/47 (month) (day) (year)
Cemetery or crematory: Westminster Cemetery
Location: Westminster Md.

18. Funeral director: J. E. Myers, Jr.
Address: Wills St. Westminster

19. 1/24/47 (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 22 19 47, at 12:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15th 19 47, to January 22 19 47
and that I last saw him alive on January 21 19 47

Immediate cause of death	Duration
(a) Coronary Occlusion	8 da.
Due to: (b) Coronary Sclerosis	
Due to: (c) moderate Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W. Glenn Fleisher M. D. or other
Address: Westminster Md. Date signed: 1/23/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00414

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 days
Hospital, institution, or street address where death occurred:
Md. Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Caroline
City or town: Federalsburg (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MONROE WILSON JOHNSON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Elizabeth Johnson
6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): Nov., 13, 1912

8. AGE: Years	Months	Days	If less than one day
34	2	5	....hrs. ....min.

9. Birthplace: Federalsburg, Md. (Town, county, and state)
10. Usual occupation: Truck Driver
11. Industry or business

FATHER
12. Name: John Johnson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Robinson
15. Birthplace: Maryland

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-21-47 (month) (day) (year)
Cemetery or crematory: Federalsburg Cem.
Location: Federalsburg, Md.
18. Funeral director: J. J. Fleming
Address: Federalsburg, Md.

19. 1-18 19 47 (Date rec'd by registrar) Alma R. Swanbeck Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 18, 19 47 at 6.35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 11, 19 47, to Jan. 18, 19 47 and that I last saw him alive on January 18, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 7th 1947
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Hyman M.D. M. D. or other
Address: Henryton, Md. Date signed 1-18-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-740 — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

50

0045 82 0

* Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: New Windsor

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: New Windsor R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Sarah C. Johnson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Roy C. Johnson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 25, 1888

8. AGE:	Years	Months	Days	If less than one day
	58	9	12	hrs. min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: housework

11. Industry or business

FATHER

12. Name: James Bostian

13. Birthplace: Md.

MOTHER

14. Maiden name: Fogle

15. Birthplace: Md.

16. Informant: Roy C. Johnson

Address: New Windsor, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 8, 1947 (month) (day) (year)

Cemetery or crematory: Haugh's

Location: near Keymar, Md.

18. Funeral director: C. O. FUSS & SON

Address: Taneytown, Md.

19. Jany 7 1947 (Date rec'd by registrar) Eunice D. Burdett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 6 1947, at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 6 1946 to Jan 6 1947 and that I last saw h.. alive on Jan 6 1947

Immediate cause of death	DURATION
Carcinoma of breast	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other

Address: Union Bridge Date signed: 1-6-47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

BC 00416

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 22 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 504 Myrtle Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Sylvia Victoria Johnson

3.(b) Social Security Number: 215-24-6504

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 11, 1927

8. AGE: Years	Months	Days	If less than one day
19	4	13	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER 12. Name: John Johnson
13. Birthplace: Virginia

MOTHER 14. Maiden name: Matilda Horsey
15. Birthplace: Maryland

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 28-47 (month) (day) (year)
Cemetery or crematory: Mount Auburn
Location: Balto Md

18. Funeral director: L. A. Williams
Address: 322 N Chrowder St

19. 1-24 (Date rec'd by registrar) 19 47 Albert R. Swankin Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24, 19 47, at 5.10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 2, 19 46, to Jan. 24, 19 47
and that I last saw her alive on January 24, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other
Address: Henryton, Md. Date signed: 1-24-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-25

2-740 — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

0417

181

Reg. Dist. No. 740

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 months

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 21 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Dorchester

City or town: Toddsville

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Marvin Jones

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 1 - 1930

8. AGE: Years: 16 | Months: 7 | Days: 23 | If less than one day: hrs. min.

9. Birthplace: Morgeard (Town, County, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Garland Jones

13. Birthplace: Md

MOTHER — 14. Maiden name: Otha Mills

15. Birthplace: Md

16. Informant: Hospital Records.

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof 1-22-47 (month) (day) (year)

Cemetery or crematory: Todd's Chapel

Location: Todd's Worcester Co. Md.

18. Funeral director: Granville A. Lecompte

Address: Cambridge, Md.

19. Jan. 25 1947 C.A. Harry Elseo

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24 1947 at 2:25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Shock	
Due to: Burns - First, second degree	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of injury: Jan 23-47

Where did injury occur? Sykesville (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?): Springfield State Hospital

Means of injury: Scalded in shower Injured at work? No.

23. SIGNATURE: James T. Marsh Deputy Medical Examiner M. D. or other

Address: Westminster Md Date signed 1-24-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13la 00418

Reg. Diat. No. 82

1. PLACE OF DEATH:

County: Carroll

City or town: Rural--Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural -- Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If roral, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: AMANDA E. KLEIN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: George L. Klein deceased

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 21, 1865

8. AGE: Years	Months	Days	If less than one day
81	1	8	hrs. min.

9. Birthplace: Frederick Co Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER 12. Name: Joseph Condon

13. Birthplace: Maryland

MOTHER 14. Maiden name: Caroline Brashears

15. Birthplace: Maryland

16. Informant: Mrs. Lewis Klein

Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 2-1-47 (month) (day) (year)

Cemetery or ~~crematory~~: Locust Grove

Location: Woodville, Frederick Co. Md.

18. Funeral director: C. L. Waltz

Address: Winfield, Md.

19. Jan. 31 1947 (Date rec'd by registrar) Thos D Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 29 1947, at 8:35 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 24 1947, to Jan 29 1947 and that I last saw h.e.r alive on January 29 1947

	DURATION
Immediate cause of death: Uremia	5 da
Due to: Chr. Interstitial Nephritis	? yrs
Due to: Arterio - Sclerosis	? yrs
Other conditions: Chr. Myocarditis	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

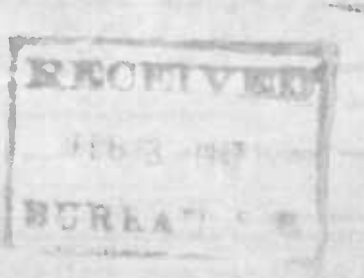
23. SIGNATURE: J. Stanley Grabill M. D. or other

Address: Detour Md Date signed 1/30/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15



1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

00419

Reg. Dist. No. 93d

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mos., 2 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 4 mos. 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County ----
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 311 S. Pulaski St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
MARY MARGARET KLINE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	separated

6.(b) Name of husband or wife unknown
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 20, 1881

8. AGE: Years	Months	Days	If less than one day
65	8	3	..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own home
FATHER 12. Name John Foland
13. Birthplace Germany
MOTHER 14. Maiden name Clementine Dimick
15. Birthplace Maryland
16. Informant Hospital records
Address
17. Burial Date thereof 1-25-47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Meadow Ridge Cemetery
Location Washington Blvd. Howard Co. Md.
18. Funeral director F. D. Weippert & Son
Address 1300 Eutaw Place
19. Jan. 24 1947 C. Barry Ward
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23 1947, at 7:25 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 21, 1946 to Jan. 23 1947
and that I last saw her alive on January 23 1947

Immediate cause of death	DURATION
Chronic Myocarditis	over 4 mos.
Due to	
Due to	
Other conditions Involutional Psychosis, Agitated Depression	3½ yrs

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Arnold H. Eichert M.D.
M. D. or other
Address S.S.H. Sykesville, Md. Date signed 1.23.47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00420

Reg. Diat. No. 710

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Mayberry

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Mayberry

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Casper Kunkle

3.(b) Social Security Number 213-01-3794

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Zelma King Kunkle

6.(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) August 18, 1881

8. AGE: Years	Months	Days	If less than one day
65	5	4	..... hrs. ..... min.

9. Birthplace Uniontown, Pa. (Town, county, and state)

10. Usual occupation Presser

11. Industry or business Clothing factory

FATHER 12. Name John Kunkle

13. Birthplace Penna.

MOTHER 14. Maiden name Elizabeth McGlaughlin

15. Birthplace Penna.

16. Informant Dr. W.C.Jeanette

Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 25, 1947 (month) (day) (year)

Cemetery or crematory Baust Church Cemetery

Location Nr. Tyrone, Md.

18. Funeral director C.O.Fuss & Son

Address Taneytown, Md.

19. Jan. 22 1947 (Date rec'd by registrar) Margaret R. Engler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 22, 1947 at 10:09 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1946 to Jan 22 1947

and that I last saw h.. alive on Jan 22 1947

Immediate cause of death	DURATION
Myocarditis (chr)	
Hypertis (chr)	
Due to	
Due to	
Other conditions Arthritis chr.	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide None Date of

Where did injury occur? None (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. C. Jeanette M.D. M. D. or other

Address Westminster Md Date signed 1-22-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00421

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Myrtle Elizabeth Leister

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

B.(b) Name of husband or wife Harold O. Leister

6.(c) If alive, give age 48 years

7. Birth date of deceased (mo., day, yr.) Jan. 27 1905

8. AGE:

Years	Months	Days	If less than one day
41	11	12	hrs. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Phillip W. Rill

13. Birthplace Carroll Co. Md.

MOTHER 14. Maiden name Susan Kilbaugh

15. Birthplace Carroll Co. Md.

16. Informant Harold O. Leister

Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 11 — 1947 (month) (day) (year)

Cemetery or crematory Westminster Cem.

Location Westminster Md.

18. Funeral director H. Bankard & Son

Address Westminster Md.

19. 1/11 1947 (Date rec'd by registrar) H. Eberhardt Registrar

MEDICAL CERTIFICATION Prior to

20. DATE OF DEATH January 9 1947, at 1:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Gunshot Wound Chest.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of injury Jan 9 - 1947

Where did injury occur Westminster (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Shot gun Wound Chest Injured at work? No

23. SIGNATURE Lester T. Moore Deputy Medical Examiner M. D. or other

Address Westminster Md Date signed 1-10-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00422

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs. 11 mon. 12 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 12 yrs. 11 mon. 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Frederick, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: David F. Linton

3. (b) Social Security Number: #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mary Catherine Linton

6.(c) If alive, give age: 82 years

7. Birth date of deceased (mo., day, yr.): March 8, 1867

8. AGE: Years	Months	Days	If less than one day
79	10	5	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Farm laborer

11. Industry or business:

FATHER
12. Name: David F. Linton
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elizabeth Forrester
15. Birthplace: Maryland

16. Informant: Springfield State Hospital Records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-15-47 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Frederick, Md.

18. Funeral director: M. K. Eichelberger & Son

Address: Frederick, Md.

19. Jan. 14 1947 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13, 1947, at 1:35 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 4, 1946, to Jan. 13, 1947 and that I last saw h... im alive on January 12, 1947

Immediate cause of death	DURATION
chronic myocarditis and myocardial deterioration	12 yrs.
Due to	
Due to	
Other conditions: Psychosis with mental deficiency and senile changes	46 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

22. SIGNATURE: Howard N. Frederickson M. D. or other

Address: Springfield State Hospital, Sykesville, Maryland Date signed 1-13-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

00423

CERTIFICATE OF DEATH

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll Co.
City or town Manchester
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, Institution, or street address where death occurred:
Long View Nursing Home
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No. 167 E. Main St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Branford Gist Lynch

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	widow

6.(b) Name of husband or wife Mr. John Lynch
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 20. 1867

8. AGE: Years 79 | Months 7 | Days 25 | If less than one day ..... hrs. ..... min.

9. Birthplace Zanesville, Ohio
(Town, county, and state)

10. Usual occupation Retired School teacher

11. Industry or business

FATHER
12. Name Joseph M. Gist
13. Birthplace Maryland

MOTHER
14. Maiden name Mary Gist
15. Birthplace Ohio

16. Informant Mrs. States Gist
Address Eldersburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 17/47 (month) (day) (year)
Cemetery or crematory Springfield Cem.
Location Sykesville Md.

18. Funeral director J. S. Myers Jr.
Address Westminster Md.

19. Jan 15 1947 (Date rec'd by registrar) Mrs. H. R. S. Denner Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 15-47 1947, at 3. a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1— 1946, to Jan 12— 1947
and that I last saw h.. alive on Jan 10 1947

Immediate cause of death	DURATION
Acute Cardiac Dilatation	2 hrs
Due to Myocarditis	6 mos
Due to Diabetes Mellitus	10 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas R Foutz M.D.
M. D. or other
Address Westminster Md. Date signed 1-15-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00424

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 14 days

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Marbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: MILDRED MARIE MACK

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Harold Mack

6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): May 13, 1921

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
25	8	0		

9. Birthplace: Welcome, Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Joseph Hart

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mamie Broctor

15. Birthplace: Unknown

16. Informant: Deceased

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/16/47 (month) (day) (year)

Cemetery or crematory: Hill Top Md

Location: Hill Top Md

18. Funeral director: Hyatt & Ryon

Address: Baldwin, Md

19. 1-13 (Date rec'd by registrar) 19 47 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13, 1947, at 2.00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 29, 1946 to Jan. 13, 1947 and that I last saw her alive on January 13, 1947

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Dec. 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Durbar W. Bowman, M.D. M. D. or other

Address: Henryton, Md. Date signed: 1-13/47

1-25

2-740-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

940 #. 00425 Reg. Dist. No. 24

P

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs. 4 mon. 5 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 18 yrs. 4 mon. 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Herbert Madsen

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1891

8. AGE: Years	Months	Days	If less than one day
56			hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

MOTHER FATHER

12. Name: George Madsen

13. Birthplace: Baltimore, Maryland

14. Maiden name: Mary E. Ensor

15. Birthplace: Baltimore, Maryland

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland 1947

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 21 (month) (day) (year)

Cemetery or crematory: Mt. Carmel

Location: Baltimore Md

18. Funeral director: Leonard D. Counton

Address: 21 W. 25th St. 8

19. 1-20 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 17, 1947, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1943 to Jan. 17, 1947 and that I last saw him alive on January 17, 1947

Immediate cause of death	DURATION
Coronary occlusion	instant
Due to	
Due to	
Other conditions: Mental deficiency without psychosis	Life

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May M.D. M. D. or Other

Springfield State Hospital
Address: Sykesville, Maryland Date signed 1-18-47

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

51 b

CERTIFICATE OF DEATH

00426

Reg. Dist. No. 76

1. PLACE OF DEATH:

County Carroll Co.

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 57 years

Hospital, institution, or street address where death occurred: 40 Longwell Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 40 Longwell Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Frank Watkins Mather

3. (b) Social Security Number 214-01-0575

4. Sex M

5. Color or race W.

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Stella Knapp Mather

6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.) April 15, 1881

8. AGE: Years 65 Months 8 Days 24 If less than one day ...... hrs. ...... min.

9. Birthplace Hartford Co. Md

(Town, county, and state)

10. Usual occupation retired merchant

11. Industry or business retail store

FATHER 12. Name Thomas William Mather

13. Birthplace Maryland

MOTHER 14. Maiden name Mary Elizabeth Keeley

15. Birthplace Maryland

16. Informant Mrs. Stella K. Mather

Address 40 Longwell Ave Westminster Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan/11/47 (month) (day) (year)

Cemetery or crematory Westminster Cemetery

Location Westminster Md.

18. Funeral director J. E. Myers Jr

Address Westminster Md.

19. 1/10 1947 (Date rec'd by registrar) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 9 1947, at 4 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 2 1944, to January 9 1947

and that I last saw him alive on January 8 1947

Immediate cause of death	DURATION
Carcinoma Prostate Secondary anemia Cachexia	2-3 yrs.

Due to

Due to

Other conditions Intestinal obstruction April 1944

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Glenn Speicher M. D. or other

Address Westminster Md Date signed 1/9/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00395

932

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll Co.
City or town: Rural near Westminster
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural near Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Spring Mills Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Bessie May Mc. Caffrey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
f.	W.	widowed

6.(b) Name of husband or wife: William E. Mc. Caffrey
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Dec. 12. 1878

8. AGE: Years: 68 | Months: 0 | Days: 26 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Silver Run Carroll Co. Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Albert Schaeffer
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary C. Fesler
15. Birthplace: New Oxford Pa.

16. Informant: Mrs. Sterling G. Mullen
Address: Westminster Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/10/47 (month) (day) (year)
Cemetery or crematory: St. Johns Cemetery
Location: Westminster Md.

18. Funeral director: J. E. Myers Jr.
Address: Taneytown Md.

19. 1/9 1947 (Date rec'd by registrar) P. L. Hawn Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 8 1947, at 8:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1940, to Jan 8 1947
and that I last saw her alive on January 6 1947

	DURATION
Immediate cause of death: Cerebral Hemorrhage	Jan 3/47
Due to: Pneumonia Hypostatic	Jan 6/47
Due to: Hypertension & myocardial degeneration	10 yrs.
Due to: Arteriosclerosis (general)	10 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ____
Means of injury: ____ Injured at work?

23. SIGNATURE: W. Glenn Speicher M. D. or other
Address: Westminster Md. Date signed 1/8/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00427

Reg. Dist. No. 740

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville - Md -
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years - 3 days -

Hospital, Institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 10 years - 3 days -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 609 Willow Ave - Govans - Baltimore - Md
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME Ella Mc Nally

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Joseph Henry McNally

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): December 31 - 1863

8. AGE: Years	Months	Days	If less than one day
83		16	..... hrs. ..... min.

9. Birthplace: Baltimore, Md -
(Town, county, and state)

10. Usual occupation: None -

11. Industry or business

FATHER
12. Name: Francis Hoban
13. Birthplace: Ireland

MOTHER
14. Maiden name: Mary Haase
15. Birthplace: Ireland -

16. Informant: Springfield State Hospital Records -
Address: Sykesville - Md -

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/20/47 (month) (day) (year)

Cemetery or crematory: Holy Redeemer
Location: Belair Rd. Balto Md.

18. Funeral director: George J. Puth Inc
Address: 1735 Harford Ave

19. 1/18 19 47 A.W. Hedrick Registrar
(Date rec'd by registrar) ams

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 16 19 47, at 9:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 13 19 36, to January 16 19 47, and that I last saw h.. alive on January 16 19 47.

Immediate cause of death	DURATION
Chronic Myocarditis and Myocardial Degeneration	3 years -
Due to: Arteriosclerosis	More than 10 years -
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: M. Virginia Beyer M.D.
M. D. or other

Address: Sykesville - Md Date signed: Jan 16 - 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74 00428

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 12 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1000 Argyle Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: WILLIAM MILES

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Vivian Miles

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 16, 1901

8. AGE: Years	Months	Days	If less than one day
46	0	12	..... hrs. ..... min.

9. Birthplace: South Carolina (Town, county, and state)
10. Usual occupation: Candy Maker
11. Industry or business:

FATHER
12. Name: Sam Miles
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Addie Star
15. Birthplace: South Carolina

16. Informant: Deceased
Address:

17. Burial, cremation, or removal. Which?: Burial. Date thereof: 2-3-47 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location: McConnellsville, S.C.
18. Funeral director: Wm. A. Jackson
Address: 916 penna ave.

19. 1-28 19 47 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 28, 1947, at 8.45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 16, 1946, to Jan., 28, 1947 and that I last saw him alive on January 28, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ..... Injured at work?

23. SIGNATURE: Reuben W. Shuman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 1-28-47

VS A15-1 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-25

2-740 — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00429

CERTIFICATE OF DEATH

Reg. Dist. No. 74 /

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 21 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No.: 2543 N. Howard Street (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ALMA MILLER

3.(b) Social Security Number: 213-26-8384

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 2, 1915

8. AGE: Years: 31 Months: 7 Days: 15 If less than one day: hrs. min.

9. Birthplace: Savannah, Georgia (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business:

FATHER
12. Name: William Miller
13. Birthplace: Georgia

MOTHER
14. Maiden name: Hattie Taylor
15. Birthplace: Georgia

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 20/1947 (month) (day) (year)
Cemetary or crematory: Mt Calvary Cemetery
Location: Ilchester, Md.

18. Funeral director: Robert E. Williams
Address: 1515 McElderry St

19. Jan. 17, 1947 (Date rec'd by registrar) Albert R. Stonebraker Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 17, 1947 at 5:10A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from November 26, 1946 to Jan. 17, 1947 and that I last saw her alive on January 17, 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Sept. 1946

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Foman, M. D. M. D. or other
Address: Henryton, Md. Date signed: 1-17-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-25

x-740 — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

83a

00430

Reg. Diat. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Frederick Myrfis

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

B.(b) Name of husband or wife Mary Josephine Wilcoxen

B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 14 - 1879

8. AGE:

Years	Months	Days	If less than one day
67	10	26	hrs. min.

9. Birthplace England (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Thomas Myrfis

13. Birthplace England

MOTHER 14. Maiden name Unknown

15. Birthplace "

16. Informant Mary Josephine Myrfis

Address Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 13-1947 (month) (day) (year)

Cemetery or crematory Deepwater Cemetery

Location Smallwood Md.

18. Funeral director H B Bankard Sons

Address

19. 1/13 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/10/47 19 at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/ /46, to 1/10/47

and that I last saw h(IM) alive on 1/10/47 19

Immediate cause of death	DURATION
Cerebral hemorrhage	4 mos
2nd Cerebral hemorrhage	2 days
Due to	
Due to Arteriosclerosis	
Other conditions Hypertension	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other

Address Date signed 1/13/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00431

Reg. Dist. No. 220

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yr., 5 mo., 19 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 20 yr., 5 mo., 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Arthur J. Phillips (alias James Arthur Phillips)

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	widowed

6.(b) Name of husband or wife: Alice

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October, , 1879

8. AGE: Years	Months	Days	If less than one day
67	3		hrs. min.

9. Birthplace: Union Bridge, Carroll Co., Md.
(Town, county, and state)

10. Usual occupation: machinist

11. Industry or business:

FATHER — 12. Name: Benjamin F. Phillips

13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Elizabeth Graham

15. Birthplace: Virginia

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 28-47 (month) (day) (year)

Cemetery or crematory: Mountain View

Location: Union Bridge Md

18. Funeral director: Raymond F Wright

Address: Union Bridge. Md.

19. Jan 26 1947 (Date rec'd by registrar) C. Harry Weaver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24 1947 at 7:04P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to Jan. 24 1947 and that I last saw him alive on January 24 1947

Immediate cause of death	DURATION
Chronic myocarditis and myocardial degeneration, about	10 yrs.
Due to: Chronic pulmonary tuberculosis	19 yrs.
Due to: Other conditions Schizophrenia, paranoid type	24 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Robert Bertrand May, M.D.
M. D. or other

Address: Springfield State Hospital, Sykesville, Maryland

Date signed: 1-24-47

VS/A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00432

CERTIFICATE OF DEATH

Reg. Dist. No. 7-0

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 yrs. 5 mon. 9 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 12 yrs. 5 mon. 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Frederick, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 126 N. South St.

(If rural, give LOCATION)

2.(a) If veteran, name war: none

3.(a) FULL NAME: George W. Poole

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 1, 1874

8. AGE:

Years	Months	Days	If less than one day
72	8	1	hrs. min.

9. Birthplace: Frederick, Maryland (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: —

FATHER

12. Name: Charles A. Poole

13. Birthplace: Frederick County

MOTHER

14. Maiden name: Victoria, Nusz

15. Birthplace: Frederick County

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal, Which?) Date thereof 1-5-1947 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Frederick-Md.

18. Funeral director: C. E. Cline & Son

Address: Frederick-Md.

19. Jan. 3 1947 (Date rec'd by registrar) C. Henry Wood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 2, 1947, at 6:25 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 24, 1946, to Jan. 2, 1947 and that I last saw him alive on January 2, 1947

Immediate cause of death	DURATION
Arteriosclerosis	12 yrs.
Due to:	
Due to:	
Other conditions: Pulmonary tuberculosis	4 yrs.
Psychosis with mental defi-	15 yrs.
ciency	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.

Robert Bertrand May M.D. M. D. or other

Address: Springfield State Hospital, Sykesville, Maryland

Date signed: 1-7-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00433

CERTIFICATE OF DEATH

Reg. Dist. No. 740

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 years, 6 months, 15 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 34 years, 6 months, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Catherine Reis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): unknown 1874

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
73	unknown			

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business:

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital records
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 3, 1947 (month) (day) (year)
Cemetery or crematory: Holy Redeemer
Location: Baltimore
18. Funeral director: Lilly & Zeiler, Inc.
Address: 403 S. Wolfe St.
19. Jan. 31 1947 (Date rec'd by registrar) C. Harry Zeiler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 30, 1947, at 5.10p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1, 1942 to January 30 1947 and that I last saw her alive on January 29 1947

	DURATION
Immediate cause of death: broncho-pneumonia	2 days
Due to: xxx arteriosclerosis over	10 years
Due to:	
Other conditions: schizophrenia, hebephrenic type more than	44 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Irene H Lehrman M.D.
M. D. or other
Address: Springfield State Hospital Date signed: 1-30-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

00434

CERTIFICATE OF DEATH

Reg. Dist. No. 740

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years, 8 months, 10 days

Hospital, institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 16 years, 8 months, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Rosie Richardson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: unknown

~~July 4, 1871~~ 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 4, 1871

8. AGE: Years	Months	Days	If less than one day
75	6	18	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: housework

11. Industry or business:

FATHER — 12. Name: James Spence

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Rosie Stoll

15. Birthplace: Germany

16. Informant: Hospital records

Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-24-47 (month) (day) (year)

Cemetery or crematory: Baltimore Cemetery

Location: Balto., Md.

18. Funeral director: John U. Ulrich

Address: 2008 Orleans St. Balto. Md.

19. Jan. 22 1947 (Date rec'd by registrar) C. Henry Klee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 22 1947, at 1.10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1 1942, to January 21 1947 and that I last saw her alive on January 21 1947

Immediate cause of death	DURATION
nephritis	more than 10 years
arteriosclerosis	more than 10 years
Due to:	
Due to:	
Other conditions: Involutional melancholia	17 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Irene Hickman, M.D. M. D. of other

Address: Springfield State Hospital Date signed: 1-22-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00435

99

CERTIFICATE OF DEATH

Reg. Dist. No. 710

1. PLACE OF DEATH:

County: Carroll

City or town: Rural Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lois A. Robertson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 8, 1893

8. AGE:	Years	Months	Days	If less than one day
	53	1	20	..... hrs. ..... min.

9. Birthplace: Carroll County, Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER — 12. Name: G. Washington Robertson

13. Birthplace: Carroll County, Md.

MOTHER — 14. Maiden name: Clara Belle Poole

15. Birthplace: Carroll County, Md.

16. Informant: Paul E. Robertson

Address: Westminster, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 30, 1947 (month) (day) (year)

Cemetery or crematory: Stone Chapel

Location: Warfieldsburg, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. Jan 30 1947 (Date rec'd by registrar) Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 28 1947, at 6 a. m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May — 1946, to Jan. 28 1947

and that I last saw h.. alive on Jan. 27 1947

Immediate cause of death	DURATION
Carcinoma of stomach	.....
Due to Arterial occlusion	.....
Due to	.....
Other conditions	.....

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: [illegible] Date signed 1-26-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

2-35

STATE OF MARYLAND—CERTIFICATE OF DEATH

00436

1. PLACE OF DEATH

County Carroll Registration Dist. No. 83

Village or City Mews Bennett No. R.D. Woodbine St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME James H. Seymour

(a) Residence: No. R.D. Woodbine Md. Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	Colored	Married

5a. If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Cora Seymour

6. DATE OF BIRTH (month, day, and year) PP 1892

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
App 55 to 60			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Laborer

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Carroll Co. (State or country) Maryland

FATHER

13. NAME Unknown

14. BIRTHPLACE (city or town) (State or country)

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT Mrs. Cora Seymour (Address) Woodbine, Md

18. BURIAL, ~~CREMATION, OR REMOVAL~~ Place White Rock Cemetery Date Jan. 7, 1947

19. UNDERTAKER C. M. Watts (Address) Winfield, Md

20. FILED Jan 7, 1947 Edna M. Hewitt Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH January (Month) 4 (Day), 1947 (Year)

22. I HEREBY CERTIFY, That I attended deceased from December 11 1946, to January 4, 1947

I last saw him alive on January 4, 1947; death is said to have occurred on the date stated above, at 8:10 A.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
hypertensive cardiovascular disease with arteriosclerosis due to chronic myocarditis and senility.	

Other **Contributory Causes** of Importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) A. H. Lawson M. D.

(Address) Sykesville, Maryland

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a **clerk**.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

82

00437

CERTIFICATE OF DEATH

Reg. Dist. No. 760

1. PLACE OF DEATH:

County: Carroll

City or town: Reese

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Reese

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural --Finksburg

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME BLANCHE E. SHAFER

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: Lewis W. Shafer

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Sept. 25, 1889

8. AGE: Years	Months	Days	If less than one day
57	4	0	....hrs. ....min.

8. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Joseph Lindsay

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Clara Baile

MOTHER — 15. Birthplace: Maryland

16. Informant: Mr. Lewis W. Shafer

Address: Finksburg, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 1-28-47 (month) (day) (year)

Cemetery or ~~crematory~~: Kriders

Location: Near Westminster, Maryland

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19. 1/27/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 25, 1947 at 11:20 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1945 to Jan 25 1947 and that I last saw her alive on Jan 25 1947

Immediate cause of death	DURATION
Cerebral Paralysis,	3 yrs +
Due to Lateral sclerosis of cord	3 yrs +
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E Reese Weltmeyer M.D. M. D. or other

Address: Westminster Md. Date signed 1/26/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00438

1640a

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or Town: Rural - Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: (Westminster / Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Kriders

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Paul Shreeve Shriner

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Married

6.(b) Name of husband or wife: Helen Stonesifer

6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): May 12 1901

8. AGE: Years	Months	Days	If less than one day
45	8	6	....hrs. ....min.

9. Birthplace: Carroll Co. Md.

(Town, county, and state)

10. Usual occupation: Butcher

11. Industry or business: Kidneys

FATHER 12. Name: Jonas Mitten Shriner

FATHER 13. Birthplace: Carroll Co. Md.

MOTHER 14. Maiden name: Isabelle Stonesifer

MOTHER 15. Birthplace: Carroll Co. Md.

18. Informant: Helen S. Shriner

Address: Westminster, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 20 1947 (month) (day) (year)

Cemetery or crematory: Fellowship Bible

Location: Uniontown, Md.

18. Funeral director: H. Rankard Bowers

Address: Westminster, Md.

19. 1/16 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 18 1947, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....

and that I last saw h... alive on ....19....

Immediate cause of death	DURATION
Strangulation by hanging	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: Jan. 18-47

Where did injury occur? Westminster (City or town) Carroll (County) Md (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Hanging by the neck Injured at work? No

23. SIGNATURE: Owen T. Monroe, Deputy Medical Examiner

M. D. or other

Address: Westminster Md Date signed: 1/18/47

1-53

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00439

Reg. Dist. No. 820

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Mt. Airy, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Mt. Airy
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: SALLIE C. SMITH

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband ~~or wife~~: John A. Smith

~~deceased~~ 6.(c) If alive, give age: years

7. Birth date of deceased (mn., day, yr.): Aug. 28, 1873

8. AGE: Years	Months	Days	If less than one day
73	4	15	hrs. min.

9. Birthplace: Frederick Co. Maryland
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER 12. Name: Jacob Strawsburg

13. Birthplace: Maryland

MOTHER 14. Maiden name: Susan Fogle

15. Birthplace: Maryland

16. Informant: Mrs. Clarence Hatfield

Address: Mt. Airy, Md.

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof 1-16-47 (month) (day) (year)

Cemetery ~~or crematory~~: Locust Grove

Location: Locust Grove, Frederick Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19. Jan. 16 1947 (Date rec'd by registrar) Wm D Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 13 1947 at 6 ~~A~~ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apl 2 1945 to Jan 13 1947 and that I last saw her alive on Jan 13 1947

Immediate cause of death	DURATION
Arteria Sclerosis	10 yrs.
Due to	
Due to	
Other conditions: Chronic valvular heart disease	10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Ernest P. Roop M.D. M. D. or other

Address: New Market Md Date signed 1-15-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

00440

CERTIFICATE OF DEATH

Reg. Dist. No. 240

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 yr., 9 mo., 8 days

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 33 yr., 9 mo., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Unknown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Bold Solvent

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): about 1864

8. AGE: Years	Months	Days	If less than one day
about 82			..... hrs. ..... min.

9. Birthplace: unknown (Town, county, and state)

10. Usual occupation: unknown

11. Industry or business

MOTHER / FATHER

12. Name: unknown

13. Birthplace: unknown

14. Maiden name: unknown

15. Birthplace: unknown

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. ~~Burial~~ (Burial, cremation, or removal. Which?) Date thereof 1-6-47 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville, Md.

18. Funeral director: C. Harry Weis

Address: Sykesville, Md.

19. Jan. 6 1947 (Date rec'd by registrar) C. Harry Weis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 5 19 47, at 7:04a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 43, to Jan. 5 19 47 and that I last saw him alive on January 4 19 47

Immediate cause of death	DURATION
Lung abscesses (multiple)	4 days
Due to: Abscess of right leg	2 mo.
Due to: Diabetes mellitus prior to	12-11-46
Other conditions: Without psychosis, mental deficiency	life

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D. M. D. or other

Springfield State Hospital

Address: Sykesville, Maryland Date signed 1-5-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00441

CERTIFICATE OF DEATH

★ Reg. Dist. No. 700

1. PLACE OF DEATH:

County Carroll

City or town Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Taneytown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John M. Staley

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Minnie Royer Staley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 19, 1867

8. AGE: Years	Months	Days	If less than one day
79	10	20	...hrs. ...min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Retired farmer

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace

MOTHER 14. Maiden name Unknown

15. Birthplace

16. Informant Mr. Birnie Staley

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 1, 1947 (month) (day) (year)

Cemetery or crematory Lutheran Cemetery

Location Taneytown, Md.

18. Funeral director C. O. Fuss & Son

Address Taneytown, Md.

19. Jan 31, 1947 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 29 1947 at 2:15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1946, to Jan. 29 1947

and that I last saw h.~~i~~ alive on Jan. 29, 1947

Immediate cause of death	DURATION
Acute Coronary Occlusion	18 hrs.
Due to Coronary Arteriosclerosis	
Due to	
Other conditions Chronic Myocarditis	
Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. S. McVaugh M.D. M. D. or other

Address Taneytown, Md. Date signed 1/31/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I MARGIN RESERVED FOR BINDING

VS A15 9-45.15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00442

Reg. Diat. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Sykesville P.O.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Margaret Regina Stoops

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Married

6.(b) Name of husband or wife: George B. Stoops

6.(c) If alive, give age: 88 years

7. Birth date of deceased (mo., day, yr.): Dec. 15, 1872

8. AGE: Years	Months	Days	If less than one day
74	0	21	....hrs. ....min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER — 12. Name: Andrew Cromwell

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Sophie Beitzel

MOTHER — 15. Birthplace: Md.

16. Informant: Mr. George B. Stoops

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 8, 1947 (month) (day) (year)

Cemetery or crematory: Springfield Cemetery

Location: Sykesville, Md.

18. Funeral director: C. Harry Klee

Address: Sykesville, Md.

19. Jan. 7 1947 C. Harry Klee

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6 1947 at 9:40 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 15, 1946 19.... to January 6 1947

and that I last saw her alive on January 6 1947

Immediate cause of death	DURATION
hypertensive cardiovascular disease	
with arteriosclerosis	
Due to diabetes mellitus	
senile changes	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W H Lawson M.D.

M. D. or other

Address: Sykesville Date signed: Jan. 6, 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00443

108

CERTIFICATE OF DEATH

Reg. Dist. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll Co.

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 15 years

Hospital, Institution, or street address where death occurred: 107 Liberty St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 107 Liberty St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Sarah Cathryn Stonch

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Widowed

6.(b) Name of husband or wife: Charles M. Stonch

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 19, 1861

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
85	8	29		

9. Birthplace: Carroll Co. Nr. New Windsor, Md.

(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER

12. Name: Solomon Brothers

13. Birthplace: Carroll Co.

MOTHER

14. Maiden name: Ellen Fowler

15. Birthplace: Carroll Co.

16. Informant: Mrs. Margaret Stuchen

Address: 107 Liberty St. Westminster

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 21 47 (month) (day) (year)

Cemetery or crematory: Westminster Cemetery

Location: Westminster Md.

18. Funeral director: J. E. Myers, Jr.

Address: Westminster Md.

19. 1/22 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 18 1947 at 3.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 30 1946 to January 18 1947 and that I last saw h.er alive on January 17 1947

Immediate cause of death: Pulmonary Lobar (unresolved) Pneumonia

Due to: Lung Abscess

Due to: Myocardial degeneration & Hypertension

Due to: Compensation

Other conditions: Fracture of Femur

(Include pregnancy within 3 months of death)

DURATION: Oct 1946 — Nov. 1945

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. Glenn Loucher M. D. or other

Address: Westminster Md. Date signed 1/20/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00444

49a

Reg. Dist. No. 79

1. PLACE OF DEATH:
County: Carroll
City or town: Hampstead Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Mo. 23 Days.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: New Jersey County:
City or town: Plainfield N.J.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3.(a) FULL NAME: Easter Genieve Sullivan

3.(b) Social Security Number: 215-09-6581

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female.	White	Single

6.(b) Name of husband or wife: —

B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 7, 1890

8. AGE: Years 56 | Months 9 | Days 5 | If less than one day: hrs. min.

9. Birthplace: Hampstead Md.
(Town, county, and state)

10. Usual occupation: Cashier.

11. Industry or business: House Restaurant. US Capital.

FATHER
12. Name: Patrick Sullivan
13. Birthplace: Staton Virginia

MOTHER
14. Maiden name: Mary Stibbs
15. Birthplace: Georgia.

16. Informant: Mrs. Walter Sullivan
Address: Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 17/47 (month) (day) (year)
Cemetery or crematory: Wesley
Location: Carroll Co Md

18. Funeral director: Edw C Tipton
Address: Hampstead Md

19. Jan. 13 1947 (Date rec'd by registrar) John S. Hughes Jr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 12 1947, at 12 25 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 18 1946 to January 11 1947 and that I last saw h— alive on January 11 1947

Immediate cause of death	DURATION
(a) —	
Generalized Carcinomatosis	
Due to: Carcinoma of Ovary	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Adeno Carcinoma Ovary
Date of op. 7-16-46
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: — Injured at work? —

23. SIGNATURE: Frank E Bankard M. D. or other
Address: Hampstead Md. Date signed 1-12-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00445

Reg. Dist. No. 74 1

1. PLACE OF DEATH:
County: Carroll
City or town: Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 2Days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
How long in hospital or institution? Colored Branch, Henryton, Maryland.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 411 Bond Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ARTHUR SUMMERS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 4, 1918

8. AGE: Years	Months	Days	If less than one day
28	10	4	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Shoe Shiner
11. Industry or business:
FATHER 12. Name: John Summers
13. Birthplace: Maryland
MOTHER 14. Maiden name: Mildred Pierce
15. Birthplace: Maryland
16. Informant: Deceased
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-15-47 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location:
18. Funeral director: Mrs Robert Elliott daughter
Address: 1129 N. Caroline St.
19. 1/11 (Date rec'd by registrar) 19 47 Albert R Swankbaum Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 11, 1947, at 9.40P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 9, 1947 to Jan., 11, 1947 and that I last saw him alive on January 11, 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1942
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of Injury: Injured at work?

23. SIGNATURE: Taylor W Brown, M.D. M. D. or other
Address: Henryton, Md. Date signed: 1/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-740 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00446

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months, 25 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henrytnn, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Jessups
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War 1

3.(a) FULL NAME: LEONARD EDWARD THOMAS

3.(b) Social Security Number: 216-05-9160

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Leeana Thomas
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 22, 1897

8. AGE:

Years	Months	Days	If less than one day
49	4	5	..... hrs. ..... min.

9. Birthplace: Gilford, Md. (Town, county, and state)
10. Usual occupation: Janitor
11. Industry or business

FATHER
12. Name: Frank Thomas
13. Birthplace: Guilford, Md.

MOTHER
14. Maiden name: Lena Harden
15. Birthplace: Guilford, Md.

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-31-47 (month) (day) (year)
Cemetery or crematory: Asbury Cemetery
Location: Camp Meade Ft. Md.
18. Funeral director: J.C. Higinbotham
Address: Ellicott City Md.

19. 1-27 (Date rec'd by registrar) 19 47 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 27 19 47 at 5.05P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 22, 1946 to Jan. 27 1947 and that I last saw him alive on January 27, 1947

Immediate cause of death: Pulmonary Tuberculosis — DURATION: March 1946
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben T. Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed 1-27-47

1-25

2-740 — 1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01048

131a

CERTIFICATE OF DEATH

Reg. Diat. No. 810

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Raymond Tucker

3.(b) Social Security Number 212-03-1055

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married.

6.(b) Name of husband or wife Clarence C. Tucker

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 9, 1882

8. AGE:

Years	Months	Days	If less than one day
64	9	21	..... hrs. ..... min.

8. Birthplace Carroll County Maryland.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Lehigh Portland Cement Co.

FATHER 12. Name John Tucker

FATHER 13. Birthplace Maryland.

MOTHER 14. Maiden name Martha Brightful

MOTHER 15. Birthplace Maryland.

18. Informant Mrs Clarence C. Tucker

Address Union Bridge, Maryland.

17. Burial Date thereof 2/2/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt Olive Cemetery

Location New Windsor - Libertytown Road

18. Funeral director D. D. Hartsuck & Sons

Address Union Bridge & New Windsor Md.

19. 2/1 1947 19 ..... Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1947, at 11.00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/20 1947, to 1-30 1947

and that I last saw him alive on 1-30 1947

Immediate cause of death	DURATION
(a) Cardiac Renal Vascular disease	3 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Phillip J. Fox M. D. or other

Address Frederick, Md. Date signed 1/31/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

95c ★ 004477

Reg. Diat. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Carroll

City or town Rural, near Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 4 yrs.

Hospital, institution, or street address where death occurred: New Bachmans Valley Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Carroll

City or town Rural near Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. New Bachmans Valley Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Lillie Maude Wachter

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married

6.(b) Name of husband or wife Luther H. M. Wachter

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 15. 1883

8. AGE:

Years	Months	Days	If less than one day
63	1	5	..... hrs. ..... min.

9. Birthplace Hampstead Fred Co. Md.

(Town, county, and state)

10. Usual occupation Home - Wife

11. Industry or business

FATHER

12. Name Jacob J. H. Messell

13. Birthplace Md.

MOTHER

14. Maiden name Catherine Spangler

15. Birthplace Md.

16. Informant Mr. Luther Wachter

Address Westminster R. D. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 22/47 (month) (day) (year)

Cemetery or crematory Uttica Cemetery

Location Near Lewistown Fred Co. Md.

18. Funeral director J. E. Mayer Jr.

Address Westminster Md.

19. 1/21 19 47 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 20th 19 47, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14th 19 47, to Jan 19 19 47 and that I last saw h[illegible] alive on Jan 19th 19 47

Immediate cause of death (a) Coronary Thrombosis

Due to Heart Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John J. Stewart M. D. or other

Address Westminster Md. Date signed Jan 20-47

1-35

Evidence for the addition of usual residence of deceased is shown on G 108 1/24/46

00446

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

49a

CERTIFICATE OF DEATH

Reg. Dist. No. 71

1. PLACE OF DEATH:

County Carroll

City or town Tyrone
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Tyrone
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Elsie Catherine Wantz

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife Elmer J. Wantz 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 27, 1893

8. AGE:

Years	Months	Days	If less than one day
53	4	17	..... hrs. ..... min.

9. Birthplace Md
(Town, county, and state)

10. Usual occupation housewife

11. Industry or business

FATHER 12. Name George A. Starner

13. Birthplace Md

MOTHER 14. Maiden name Sarah Jane Zepp

15. Birthplace Md

16. Informant Elmer J. Wantz

Address Westminster R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 16, 1947 (month) (day) (year)

Cemetery or crematory St. Matthews

Location Pleasant Valley, Md.

18. Funeral director C. O. FUSS & SON

Address Taneytown, Md.

19. Jan. 16 1947 (Date rec'd by registrar) Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 13th 1947, at 2.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10th 1946, to January 13th 1947, and that I last saw h[illegible] alive on January 13th 1947

Immediate cause of death	DURATION
Carcinoma of Ovary	8 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma Ovary - Uterus - Cervix Dept. Date of op. July 1st 1946

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE S. Luther Bair (M.D.) M. D. or other

Address Baltimore, Md. Date signed 1/14/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

U0449

CERTIFICATE OF DEATH

Reg. Diat. No. 79

1. PLACE OF DEATH:
County Carroll Co
City or town Detour Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 56 yr
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary Louisa Myerly Warren

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	Married

6.(b) Name of husband or wife James S. Warner

7. Birth date of deceased (mo., day, yr.) Dec 16 1861 6.(c) If alive, give age 85 years

Oct 4 1864

8. AGE:

Years	Months	Days	If less than one day
82	3	5	hrs. min.

9. Birthplace Carroll Co Md
(Town, county, and state)

10. Usual occupation Home Wife

11. Industry or business

FATHER
12. Name Andrew Myerly
13. Birthplace Pa

MOTHER
14. Maiden name Mary Madeline Martin
15. Birthplace Pa

16. Informant James S. Warner
Address Detour Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 18-47 (month) (day) (year)
Cemetery or crematory Keysville Cemetery
Location Keysville Md
18. Funeral director Raymond K. Knight
Address Union Bridge. Md

19. Jan. 16 1947 (Date rec'd by registrar) Fanny M. Nice Powell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16 1947 at 3 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1947 to Jan 16 1947
and that I last saw her alive on Jan 16 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to Arterio Sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D. N. Legg M. D. or other
Address Union Bridge Date signed 1-16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 741 — 00450

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr, 4 Mo's, 27 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Harford
City or town: Edgewood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: BESSIE MARIE WASHINGTON

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: John W. Washington
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): September 19, 1903

8. AGE: Years	Months	Days	If less than one day
43	4	11	hrs. min.

9. Birthplace: New York, N. Y. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: William Brown
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Elizabeth Thomas
15. Birthplace: Ireland

16. Informant: Deceased
Address

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 1-3-47 (month) (day) (year)
Cemetery or crematory
Location Abington Methodist Church
18. Funeral director Mrs. Frances A. Hensley.
Address 578 W. Biddle st.

19. 1-30 19 47 Albert R. Lenhardt Deputy Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30, 19 47 at 5.00A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 3, 19 45 to Jan., 30, 19 47 and that I last saw her alive on January 30, 19 47

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben W. Kwan, M. D.
M. D. or other
Address Henryton, Md. Date signed 1-30-47

1-25

2-240-1-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97 — 00451

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 11 mo., 4 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 1 yr., 11 mo., 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 723 N. Collington Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: Joseph J. Wetzelberger

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 2, 1873

8. AGE: Years	Months	Days	If less than one day
73	2	18	hrs. min.

9. Birthplace: Baltimore City, Maryland
(Town, county, and state)

10. Usual occupation: floor walker

11. Industry or business: department store

MOTHER FATHER

12. Name: Aloysius Wetzelberger

13. Birthplace: Alsace Lorraine

14. Maiden name: Elizabeth Kuhber

15. Birthplace: Alsace Lorraine

16. Informant: Springfield State Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-22-47 (month) (day) (year)

Cemetery or crematory: Holy Redeemer

Location: Baltimore

18. Funeral director: Leonard J. Ruck

Address: 5305 Harford Road

19. Jan. 20 1947 C. [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 20 1947, at 4:50A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2 1945, to Jan. 20 1947 and that I last saw him alive on January 19 1947

Immediate cause of death	DURATION
Arteriosclerosis, more than	3 yrs.
Due to:	
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	3 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
M. D. or other

Springfield State Hospital
Address: Sykesville, Maryland Date signed 1-20-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

★ 00452 Reg. Dist. No. 94a

1. PLACE OF DEATH:

County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year 2 months

Hospital, institution, or street address where death occured:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Sykesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Carleton Emery White

3.(b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Erma Pfaff

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 24, 1883

8. AGE:

Years	Months	Days	If less than one day
63	5	28	..... hrs. ..... min.

9. Birthplace Winston-Salem, N. C.

(Town, county, and state)

10. Usual occupation Minister

11. Industry or business Presbyterian Church

FATHER

12. Name James White

13. Birthplace N.C.

MOTHER

14. Maiden name Mary Lee Scruggs

15. Birthplace N.C.

16. Informant Mrs. Erma White

Address Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 23, 1947 (month) (day) (year)

Cemetery or crematory Springfield Cemetery

Location Sykesville, Md.

18. Funeral director C. Harry Weer

Address Sykesville, Md.

19. Jan. 23 1947 C. Harry Weer

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 21 1947 at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 21st 1947, to Jan 21 1947 and that I last saw him alive on Jan 21st 1947

Immediate cause of death	DURATION
Coronary Thrombosis	1 hr
Due to	
Gen arteriosclerosis ?	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. H. Weston M.D.

M. D. or Other

Address Sykesville Md. Date signed 1/24/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If not known, state age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

00453

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 760

1. PLACE OF DEATH:
County: Carroll
City or town: Rural Westminster R.D.I
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural Westminster R. D. I
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Eliza Jane Willet

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Henry Willet
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): September 3 1869

8. AGE: Years	Months	Days	If less than one day
77	4	2	hrs. min.

9. Birthplace: Carroll County, Md.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: In Family Home.

FATHER
12. Name: Amos Study
13. Birthplace: Carroll County, Md.

MOTHER
14. Maiden name: Sarah Feeser
15. Birthplace: Carroll County, Md.

16. Informant: Mrs Edward Plunkert
Address: Westminster, Md. R. D. I

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 8 1947 (month) (day) (year)
Cemetery or crematory: St. Marys Union Cemetery
Location: Silver Run, Md.

18. Funeral director: T. M. Teale & Son
Address: Littlestown, Pa. Per R. A. Teale

19. 1/6 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 5th. 1947 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 13 1946, to Jan 5 1947
and that I last saw her alive on January 4 1947
Immediate cause of death: Cardio Vascular Renal disease c Hypertension, myocardial
Due to: Degeneration
Due to: Arterio Sclerosis (general)
Other conditions:
(Include pregnancy within 3 months of death)

DURATION: Several yrs.

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. Glenn Speicher M. D. or other
Address: Westminster Md. Date signed: 1/6/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35